Illinois Department of Public Aid

no. M-200-02-01

ILLINOIS MEDICAL ASSISTANCE PROGRAM
PROVIDER BULLETIN

12/20/02

TO: Participating Durable Medical Equipment and Supply Providers

RE: Handbook for Medical Equipment and Supplies December 2002 Update

The Handbook for Medical Equipment and Supplies has been revised. The changes are reported on replacement pages available on the Department's website at <**http://www.state.il.us/dpa/html/durable_medical_equipment_supp.htm**>.

The documents are in Adobe Portable Document Format (PDF). In order to view or print the documents, you will need to have Adobe Acrobat Reader installed on your computer. Adobe Acrobat Reader is available to download FREE from the Adobe homepage at < **http://www.adobe.com**>.

If you do not have access to the Internet, or need a paper copy, printed copies are available upon written request. You need to specify a physical street address to ensure delivery. Submit your written request or fax to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Fax Number: (217) 557-8800
E-mail address is **PPU@mail.idpa.state.il.us**

The revised pages are dated December 2002. The affected items are designated by "=" signs to the left. This Provider Bulletin lists the pages to be removed and replaced.

INSTRUCTIONS FOR UPDATING HANDBOOK

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CHAPTER M-200

DURABLE MEDICAL EQUIPMENT AND SUPPLIES

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M-203 COVERED SERVICES

A covered service is an item or service for which payment can be made. The services covered in the program include only those reasonably necessary medical and remedial services which are recognized as standard medical care required for immediate health and well-being because of illness, disability, infirmity or impairment.

> Certain services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.

A written recommendation (order) or plan of care signed and dated by the patient's physician is required for the provision of medical supplies and equipment. Either electronic or handwritten dates are acceptable. Orders transmitted by telefax are acceptable, provided it is clear from the contents that the physician personally signed the original order. Multiple page orders must have the patient's name on every page.

Orders with signature stamps or on which the physician's name was signed and initialed by a nurse are **not** accepted by the Department as valid physician orders. A plan of treatment by a home health agency is **not** accepted by the Department as a valid physician order for medical equipment and supplies.

A podiatrist's order for items required for care of the foot or ankle will be accepted, subject to the same restrictions and policies as a physician's order.

= Items ordered by an advanced practice nurse, pursuant to a current written collaborative or practice agreement required by the Nursing and Advanced Practice Nursing Act [225 ILCS 65] and implementing rules (68 Ill. Adm. Code 1300), will be covered to the extent that the item would be covered if it were ordered by a physician. All orders written and signed by advanced practice nurses must indicate their credentials as well as the name of the collaborating physician.

= Items ordered by a physician assistant, pursuant to written guidelines required by the Physician Assistant Practice Act of 1987 [225 ILCS 95] and implementing rules (68 Ill. Adm. Code 1350), will be covered to the extent that the item would be covered if it were ordered by a physician. All orders written and signed by physician assistants must indicate their credentials as well as the name of the supervising physician.

A prescription signed by a pharmacist will be accepted for medical supplies and non-durable equipment, provided the signing pharmacist received the contents as a verbal order from the physician whose name is being used on the prescription. A copy of the prescription must be retained by the pharmacy.

Coverage is limited to those items which are specifically included in the physician's written order. Items which are added to the order by the supplying provider will not be covered unless a supplemental order is signed by the physician.

The following general types of services are covered, subject to the limitations described in this handbook:

Nondurable Medical Supplies - Items which have a limited life expectancy, including but not limited to surgical dressings, bandages, disposable syringes, etc. These items are used for an individual's care for life maintenance or to expedite hospital discharge and enable the person to be cared for at home.

Durable Medical Equipment - Items which can withstand repeated use, are primarily designed for medical purposes, generally not useful in the absence of illness or injury and appropriate for use in the home.

Prostheses and Orthoses - Corrective or supportive devices prescribed to artificially replace a missing portion of the body or to prevent or correct physical deformity or malfunction, or to support a weak or deformed portion of the body.

Respiratory Equipment and Supplies - Respiratory items, including oxygen, necessary as a life saving measure, for prevention of a medical emergency or institutionalization, or to facilitate deinstitutionalization.

Repair, Alterations and Maintenance - Repair, alteration and maintenance of necessary durable medical equipment, prostheses, orthoses and hearing aids is limited to patient-owned items.

Rental of Medical Equipment - Under certain circumstances, such as when a patient's need is known to be temporary, coverage will be for rental rather than purchase of an item.

Monaural or binaural hearing aids required to improve or correct a hearing deficit are a covered service. Refer to the Handbook for Audiology Services for policies on coverage and prior approval for hearing aids.

Eyeglasses and other devices to correct vision are a covered service. Refer to the Handbook for Optometric Services for policies on coverage and limitations.

Refer to Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, Foreword, for instructions on obtaining copies of handbooks.

Any question a provider may have about coverage of a particular service or item is to be directed to the Department prior to the provision of the service. Providers may call the Bureau of Comprehensive Health Services at (217)782-5565.

M-211.4 DENIAL OF ITEM OR SERVICE

If the item requested is denied, a computer-generated Form DPA 3076C, Notice of Decision on Request For Medical Service/Equipment, citing the denial reason, will be sent to the patient, the local DHS office and the supplying provider. The provider cannot file an appeal of the denial. If the provider obtains additional information that could result in a reversal of the denial, the provider may submit a new prior approval request with the supporting medical information attached.

M-211.5 TIMELINES

The Department is obligated to make a decision on prior approval requests within specified time frames. In general, decisions must be made within 30 days of receipt of a properly completed request, with exceptions as described below. If no decision has been made within the 30 day period, the item is automatically approved. If an item has been automatically approved, reimbursement will be made at the provider's charge or the Department's maximum rate, whichever is less.

Exceptions:

- Decisions to approve or deny requests for artificial limbs or braces must be made within 21 days after receipt of the request.
- Decisions to approve or deny requests for **standard** wheelchairs or hospital beds must be made within 21 days after receipt of the request.
- Decisions to approve or deny requests for medical supplies costing less than $100 must be made within 21 days after receipt of the request.

If the request is incomplete or requires further information to be properly considered, the Department may request additional information from either the supplying provider or the physician who ordered the service. If additional information is requested within 14 days of receipt of the prior approval request, the 30 day period stops. When the required information is received, a new 30 day period begins.

M-211.6 POST APPROVALS

Post approval may be requested. Post approval may be granted upon consideration of individual circumstances, such as:

- Determination of the patient's eligibility for the Medical Assistance Program or for KidCare was delayed or approval of the application had not been issued as of the date of service. In such a case, the post approval request must be received no later than 90 days following the Department's Notice of Decision approving the patient's application.

- Urgently needed equipment or supplies were provided due to a medical need which arose unexpectedly outside the Department's normal business hours, so prior approval could not be requested from the Department. In such a case, to receive an expedited decision, the post approval request must be received on the first business day after delivery of the items.
- There was a reasonable expectation that other third party resources would cover the item and those third parties denied payment after the item was supplied. To be considered under this exception, documentation that the provider billed a third party payor within six months following the date of service, as well as a copy of the denial from that third party must be supplied with the request for approval. The request for post approval must be received no later than 90 days from the date of final adjudication by the third party.
- The patient did not inform the provider of his or her eligibility for Medical Assistance or KidCare. In such a case, the post approval request must be received no later than six months following the date of service to be considered for payment. To be considered under this exception, documentation of the provider's dated, private-pay bills or collection correspondence, that were addressed and mailed to the patient each month following the date of service, must be supplied with the request for approval.

To be eligible for post approval consideration, all the normal requirements for prior approval of the item must be met and the post approval requests must be received by the Department no later than 90 days from the date services or items are provided or within the time frames identified above.

=M-211.7 BOGARD CLASS MEMBERS

Pursuant to a court-ordered consent decree entered in 1993 in the class action case **Bogard v DPA, et al**, 88 C 2414, all eligible participants who are members of the court-approved class are assigned Individual Service Coordinators (ISCs). These ISCs are responsible for planning and coordinating all care for the Bogard class members, including obtaining necessary medical equipment and supplies. Bogard class members are generally persons over age 18 with developmental disabilities who resided in an ICF or SNF as a Medicaid recipient for a period of more than 120 days, in the aggregate, between March 23, 1986 through April 1, 1994.

When a Bogard class member has a medical need for equipment or supplies, the ISC contacts a DME provider to arrange delivery of the needed items. If the items require prior approval, the ISC will work with the DME provider to complete a Form DPA 2240, which the ISC will submit to the Department for approval.

All other policies and procedures contained in this handbook are applicable for services or items provided to Bogard class members.

was using C-PAP, or evidence that the patient could not tolerate C-PAP,
- Evidence that the use of the BiPAP equipment by the patient did alleviate the threat to life as documented by a sleep monitoring test while the patient was using BiPAP, and
- A signed and dated physician's order for the device which includes a certification by the physician that the patient has shown the desire and ability to fully utilize the BiPAP device during sleep.

Appendix M-5 contains a facsimile of Form DPA 3701F, C-PAP/BiPAP Rental Request. This form provides a convenient format for supplying the required information, however, the Department does not require that the form itself be used if all the required medical information is supplied in another format. If the initial request fails to include all of the information described above, the Department will send a copy of Form DPA 3701F to the DME provider for completion by the attending physician. Consideration and processing of the request will be delayed pending receipt of the required information.

Initial approvals will be for a rental for a three-month trial period. Renewals after the trial period will require a new prior approval. A request for renewal should include a signed and dated statement from the physician that:
- The patient has been compliant with the use of the C-PAP/BiPAP and with the treatment plan and that the C-PAP/BiPAP continues to relieve the patient's apnea and anoxemia,
- Provides an updated plan of care, including the anticipated duration of medical need, and
- Provides an assessment of the possible appropriateness of surgical intervention.

Copies of all follow-up sleep studies done during the trial period should also be included.

M-212.22 Oxygen Supplies and Equipment

= Requests for oxygen, oxygen equipment and oxygen concentrators must include measurements of arterial PO_2 or arterial oxygen saturation. For requests for continuation of oxygen therapy, a pulse oximetry is acceptable.

The physician's order must specify the O_2 liter flow rate required by the patient and the frequency of use.

If arterial PO_2 is above 55 mm Hg or arterial O_2 saturation is above 88% at rest on room air, a statement from the prescribing physician explaining the basis for medical necessity must be included with the request.

= If patient's pulse oximetry is 89%, they must be retested in 90 days on room air at rest, and a copy of results submitted with a new request, along with the diagnosis and order for O_2 signed by the treating physician.

Long Term Care (LTC) facilities have the option of billing the Department directly for oxygen for their residents, or obtaining oxygen from a DME provider, with the DME provider billing the Department. No matter which provider bills for the services, oxygen concentrators and tank refills for LTC residents do **not** require prior approval.

When an LTC facility obtains oxygen equipment and supplies from a DME provider, **both** providers must exercise care to ensure that the Department is not billed twice for the same service. The LTC facility is responsible for the cost of the first tank of oxygen used by a resident each month. The first tank is defined as:

- One "H" tank (6900 liters) or
- Two "E" tanks (623 liters) or
- 20 pounds of liquid oxygen.

The cost of this first tank for each resident each month may **not** be billed to the Department by the DME provider. The remaining tanks or refills may be billed to the Department by either the DME provider or the LTC facility, but not by both.

M-212.23 Apnea Monitors

Requests for prior approval for an apnea monitor must be accompanied by the attending physician's evaluation of the patient's condition, including diagnosis, evidence of apneic episodes and expected duration of the need for the monitor.

Apnea monitors are approved for rental only. The rental amount is to include all supplies needed for the use of the apnea monitor. These items include, but are not limited to, belts, electrodes, wires and ambu bag. Supply items for an apnea monitor may be approved only if the apnea monitor is owned by the patient.

For requests for extended rental periods or for renewal requests, the Department may require evaluation of monitor event recordings for evidence of apneic events and compliance in use of the monitor.

No payment will be allowed for pneumograms or separate respiratory event recordings provided in the home because most modern apnea monitors have the capacity to provide event recordings. These recordings can be evaluated for presence of true apneic events, as opposed to artifacts such as false alarms due to misplacement of sensors.